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Simplifying the Law in Medical Malpractice: The Use of Practice Guidelines as the Standard of Care in Medical Malpractice Litigation

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SIMPLIFYING THE LAW IN MEDICAL MALPRACTICE: THE USE OF PRACTICE GUIDELINES AS THE STANDARD OF CARE IN MEDICAL MALPRACTICE LITIGATION

I. INTRODUCTION

In 1934, when he commented on medical malpractice in West Virginia,[1] Hale J. Posten must have gazed into a crystal ball. He noted:

> As the practice of medicine in its various branches tends to become a business rather than a personal relation, and the paternal position of the family physician fades into the limbo of forgotten things, it is likely that actions against doctors for their acts of negligence in the exercise of their art will become more, rather than less, frequent.[2]

Indeed, the frequency, as well as the costs, of medical malpractice litigation have risen markedly since the 1930s, particularly in the 1980s.[3] As a result, many physicians turned to the practice of "defensive medicine" in order to avoid potentially costly malpractice lawsuits.[4] The consequences of defensive medicine are rising costs of medical services for patients and rising malpractice insurance premiums for physicians.[5] Recently, physicians, insurers, and lawyers have become increasingly interested in the development of practice guidelines[6]

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1. *See* Hale J. Posten, *The Law of Medical Malpractice in West Virginia*, 41 W. VA. L.Q. 35 (1935).

2. *Id.*

3. *See* U.S. GENERAL ACCOUNTING OFFICE, MEDICAL MALPRACTICE: NO AGREEMENT ON THE PROBLEMS OF SOLUTIONS (1986); DEPARTMENT OF HEALTH AND HUMAN SERVS., REPORT OF THE TASK FORCE ON MEDICAL LIABILITY AND MALPRACTICE 3-6 (1987).

4. *See* J. E. Harris, *Defensive Medicine It Costs, But Does it Work?*, 257 JAMA 2801 (1987).

5. *See* S. Zuckerman, *Medical Malpractice: Claims, Legal Costs, and the Practice of Defensive Medicine*, HEALTH AFF. 128 (Fall 1984).

6. This Note uses the term "practice guidelines" in place of many terms that are presently used by other commentators that mean essentially the same thing. There are as many terms used to describe practice guidelines as there are organizations interested in their development. The American Medical Association, for example, uses the term 'practice parameters' because this term is

> [I]ntended to encompass (1) standards, which are generally accepted principles for patient management; (2) guidelines, which are recommendations for patient management that may identify a particular management strategy or a range of strategies; and (3) other patient management strategies such as practice options and practice advisories. Other organizations and commentators use other terms, such as "practice guidelines" [i.e., The U.S. General Accounting Office], or "practice policies" for

— strategies that will assist physicians in clinical decision-making.[7] Development of these guidelines will help physicians practice medicine in a fashion that assures high quality and cost-effectiveness.[8]

Increased interest in practice guidelines invites inquiry into the effect of such guidelines on the legal side of medicine — medical malpractice litigation. Current standards in medical malpractice litigation fail to provide either the plaintiff or the defendant with a clear understanding of the standard of care physicians owe to their patients.[9] Furthermore, the applicable liability standard in medical malpractice cases must be proved by expert testimony.[10] Each party hires one or more experts who attempt to match wits on the stand. This "battle of the experts" is not simply an imaginative creation in the minds of critics; it is the reality of present medical malpractice litigation. Even in West Virginia, the Supreme Court of Appeals has observed that:

> [I]t is obvious that from the abundance of medical malpractice cases that go to trial around the United States, and from the profusion of medical experts advertising their services in the back of legal magazines, that many doctors will gladly don their boxing gloves for a reasonable fee and testify about malpractice matters.[11]

This comparison of physician experts to fighters illustrates the perception of medical malpractice trials even among experienced advocates and judges. Arguably, a "battle of the experts" is not the way to con-

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essentially the same concept . . . .

Edward B. Hirshfeld, *Should Practice Parameters be the Standard of Care in Malpractice Litigation?*, 266 JAMA 2886 (1991).

Generally, a "practice guideline" is defined as a "standardized specification for care developed by a formal process that incorporates the best scientific evidence of effectiveness with expert opinion." Lucian L. Leape, *Practice Guidelines and Standards: An Overview*, 16 QUALITY REV. BULL. 42, 43 (1990).

7. Edward B. Hirshfeld, *Practice Parameters and the Malpractice Liability of Physicians*, 263 JAMA 1556 (1990).

8. Robert H. Brook, *Practice Guidelines and Practicing Medicine: Are They Compatible?*, 262 JAMA 3027-30 (1989).

9. For a discussion of the standard of care in medical malpractice litigation, *see infra* Part II.

10. *See* Page Keeton, *Medical Negligence — The Standard of Care*, 10 TEX. TECH L. REV. 351, 351-54 (1979).

11. Farley v. Meadows, 404 S.E.2d 537, 540 (W. Va. 1991).

duct a negligence trial. A set of practice standards embodied in well-established guidelines would, as this Note will propose, do away with much of the need for these smooth-talking hired guns.

Furthermore, the implementation of practice guidelines as conclusive pronouncements of appropriate standards of care in particular clinical situations will increase the numbers of valid negligence claims while decreasing claims that are frivolous. Some studies indicate that too few valid malpractice claims[12] are actually filed.[13] For example, the Harvard Medical Practice Study found that between 1975 and 1989, seven to eight times as many patients suffered a treatment-related injury as filed a malpractice claim.[14] At the same time, neither negligence nor injury was found in nearly eighty-five percent of malpractice claims that were filed.[15] Thus, it appears that many claimants and their lawyers do not understand the applicable standard of care in malpractice actions or whether the standard was met in their particular case.[16] The lack of definitive standards of care, therefore, may also account for the failure of legitimately injured patients to bring claims against their physicians.[17]

This Note does not endorse the use of practice guidelines in order to decrease the amount of medical malpractice litigation. Indeed, as evident from the Harvard Medical Practice Study, an *increase* rather than a decrease in the number of viable malpractice claims is in order.[18] However, practice guidelines will ensure that courts award damages to injured patients only where physicians fail to meet the applicable standard of care.

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12. A valid malpractice claim is one where an injury occurred as a result of a physician's negligence, as opposed to no injury or no negligence.

13. *See, e.g.,* 1976 CALIFORNIA MEDICAL ASSOCIATION, MEDICAL INSURANCE FEASIBILITY STUDY, SACRAMENTO, CA; 1990 HARVARD MEDICAL SCHOOL, HARVARD MEDICAL PRACTICE STUDY: PATIENTS, LAWYERS AND DOCTORS, CAMBRIDGE, MA [hereinafter HARVARD STUDY].

14. HARVARD STUDY, *supra* note 13.

15. *Id.*

16. Troyen A. Brennan, *Practice Guidelines and Malpractice Litigation: Collision or Cohesion?*, 16 J. HEALTH POL. POL'Y & L. 67, 69 (1991).

17. *Id.* at 69.

18. HARVARD STUDY, *supra* note 13.

Practice guidelines, when properly developed,[19] have the potential to be highly influential in determining the standard of care applicable to particular defendant physicians in medical malpractice lawsuits. In order to understand the practical effect of practice guidelines in litigation, Part II of this Note provides a general overview of the tort of negligence and the existing methodology for determining the standard of care in medical malpractice litigation in general, and in West Virginia. Part III of this Note examines the history of practice guidelines and the various theories underlying their development. Part IV of this Note addresses the potential beneficial impact of practice guidelines on the existing law of medical malpractice. Finally, Part V of this Note proposes legislative action to adopt practice guidelines as conclusive pronouncements of the standard of care for West Virginia physicians.

II. BACKGROUND

Medical malpractice cases are nothing other than more complicated ordinary negligence cases. The plaintiff's elements of proof are the same — duty or standard of care, breach, and resulting injury. The primary difference between the two causes of action is the presentation of evidence to establish the standard of care at trial. In conventional negligence cases, testimony of a lay witness or the presentation of other evidence establishes this element. However, in medical malpractice cases, only the testimony of an expert witness establishes this most important element of the case. A discussion of the general principles of each cause of action follows.

A. The Standard of Care in Conventional Negligence Cases

Negligence is defined by the Restatement (Second) of Torts as "conduct which falls below the standard established by law for the protection of others against unreasonable risk of harm."[20] In order to recover damages in negligence actions, the plaintiff must allege and prove three separate elements: (1) injury to the plaintiff; (2) fault on

19. For a complete discussion on the formulation of guidelines, *see infra* Part III.B.
20. RESTATEMENT (SECOND) OF TORTS § 282 (1977) [hereinafter RESTATEMENT].

the part of the defendant; and (3) that the defendant's fault was the legal cause of the injury to the plaintiff.[21]

To establish fault, a plaintiff must prove that the defendant owed and breached a legal duty not to expose the plaintiff to a reasonably foreseeable risk of injury.[22] In conventional negligence actions, the plaintiff establishes a defendant's breach of this duty by establishing that the defendant did not meet the applicable standard of care. Today, this standard of care may be established by statute, regulation, or prior judicial decision.[23]

In most circumstances, the defendant's conduct is measured by the "reasonable person" standard.[24] This standard measures the defendant's conduct by comparing it to the conduct of a hypothetical reasonable person in like or similar circumstances.[25] In typical negligence cases, when the conduct in question is within the understanding of lay persons, the jury is the ultimate judge of whether the defendant's conduct was appropriate.[26] Specifically, the jury decides whether the defendant should have recognized the risk of his conduct,[27] and in light of that risk, whether the defendant's conduct was reasonable.[28]

Customs existing in various industries, as well as standards created by organizations in those industries, are often used as evidence to establish the appropriate standard of care.[29] The origin of the use of customs dates back to the beginning of this century. In 1903, Justice Oliver Wendell Holmes stated: "What usually is done may be evidence of what ought to be done."[30] However, courts must limit the use of

21. G. CHRISTIE, CASES AND MATERIALS ON THE LAW OF TORTS 109 (1983).
22. *Id.*
23. RESTATEMENT, *supra* note 20, § 285.
24. *Id.* § 283.
25. *Id.*
26. Mark A. Hall, *The Defensive Effect of Medical Practice Policies in Malpractice Litigation*, 54-2 LAW & CONTEMP. PROBS. 119, 126 (1991).
27. RESTATEMENT, *supra* note 20, §§ 289-90.
28. *Id.* at § 291.
29. *See, e.g.*, Shafer v. H. B. Thomas Co., 146 A.2d 483, 485 (N.J. 1958); Pan Am. Petroleum Corp. v. Like, 381 P.2d 70, 76 (Wyo. 1963). *See also* W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 33, at 193-96 (5th ed. 1984) [hereinafter PROSSER & KEATON].
30. Texas & Pac. Ry. v. Behymer, 189 U.S. 468, 470 (1903).

customs in negligence cases because "[c]ourts must in the end say what is required; there are precautions so imperative that even their universal disregard will not excuse their omission."[31] Thus, evidence of custom is not an absolute determinant of the standard of care in a conventional negligence case. In fact, some courts have found that following a custom may itself be found to be negligent.[32]

Conventional negligence law imposes a duty of reasonable conduct on the part of defendants. If this duty is breached and injury results, the defendant is liable for that injury. Custom is one method of establishing the relevant duty of the defendant in a negligence case. As the following discussion indicates, the role of custom plays a much more important role in medical malpractice litigation.

B. The Standard of Care in Medical Malpractice Cases

"Medical malpractice is the tort of negligence committed by physicians and other health care professionals."[33] Like traditional negligence actions, the law charges the plaintiff in a medical malpractice action with the burden of proof for each aforementioned element: injury, fault, and causation. While the jury is able to determine the appropriate standard of care on its own in conventional negligence cases, this task is far more complicated in medical negligence cases.

1. Background

Stated generally, a physician's standard of care is that degree of care and skill employed by qualified physicians in the same "school" as the defendant physician.[34] However, most states impose limitations

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31. The T. J. Hooper, 60 F.2d 737, 740 (2d Cir. 1932).

32. *See, e.g.*, The T. J. Hooper, 60 F.2d 737 (2d Cir. 1932), *cert. denied*, Eastern Transp. Co. v. Northern Barge Corp., 287 U.S. 662 (1932); Dempsey v. Addison Crane Co., 247 F. Supp. 584 (D. D.C. 1965). *See also* Clarence Morris, *Custom and Negligence*, 42 COLUM. L. REV. 1147, 1149, 1158 (1942).

33. Eleanor D. Kinney & Marilyn M. Wilder, *Medical Standard Setting in the Current Malpractice Environment: Problems and Possibilities*, 22 U.C. DAVIS L. REV. 421, 438 (1989).

34. PROSSER & KEETON, *supra* note 29, § 32, at 187.

regarding comparison of the defendant's conduct to the conduct of other physicians. These limitations are based on either the defendant physician's locality or, following the recent trend,[35] the defendant physician's field of specialization.[36]

Until recently,[37] physicians were bound to meet the standard of care determined by other physicians in the same locality.[38] This "locality rule" often made it extremely difficult for plaintiffs to establish a local standard because local doctors were unwilling to testify against one another.[39] Without an expert familiar with the standard practice in the community, it was impossible for plaintiffs to establish the local standard of care. The potential for unjustifiable divergence in standards of medical care based solely on geography, particularly given modern access to technology in almost all communities, led most states to rethink their strict approach to the locality rule.[40]

As a result, strict interpretation of the locality rule in most states has given way to a broader version of the rule. In most states, the locality rule now states that a defendant physician is to be compared to physicians practicing in the same or *similar* locality.[41] At least one court has even suggested that, because of modern communication and transportation, all physicians should be held to a national standard of

35. The modern trend of most jurisdictions is to abandon the "strict locality rule" in favor of a broader version of the rule. *See infra* notes 36-43 and accompanying text. *See also* Annotation, *Modern Status of "Locality Rule" in Malpractice Actions Against Physician Who Is Not a Specialist*, 99 A.L.R. 3D 1133 (1980).

36. Annotation, *Modern Status of "Locality Rule" in Malpractice Actions Against Physician Who is Not A Specialist*, 99 A.L.R. 3D 1133 (1980) [hereinafter *Modern Status*].

37. By the middle of the century, most states had abandoned the "strict locality" rule in favor of the modern "similar physician" rule. *See* Kinney & Wilder, *supra* note 33, at 441.

38. *See* PROSSER & KEETON, *supra* note 29, § 32, at 188.

39. Kinney & Wilder, *supra* note 33, at 441.

40. *See, e.g.*, Hundley v. Martinez, 158 S.E.2d 159, 166-67 (W. Va. 1967); Paintiff v. City of Parkersburg, 345 S.E.2d 564 (W. Va. 1986).

41. *See Modern Status*, *supra* note 36; Annotation, *Malpractice Testimony: Competency of Physician of Surgeon from One Locality to Testify, in Malpractice Case, As to Standard of Care Required of Defendant Practicing in Another Locality*, 37 A.L.R. 3D 420 (1971); Annotation, *Standard of Care Owed to Patient by Medical Specialist as Determined by Local, "Like Community," State, National, or Other Standards*, 18 A.L.R. 4TH 603 (1982) [hereinafter *Standard of Care*].

care.[42] Almost all states have incorporated a national standard of care for specialists.[43] Nonetheless, no state has moved wholly to national standards for all physicians.[44]

2. Establishing the Standard of Care

Because the standard of care in any given medical malpractice case is based on the performance of physicians in the same industry, custom plays a much greater role in medical malpractice litigation than in conventional negligence.[45] In medical malpractice litigation, "it is thought that the jury lacks sufficient expertise to evaluate independently the propriety of physicians' conduct. Therefore, jurors are instructed to judge physicians not by the jury's sense of what is right, but by the custom that prevails in the profession."[46] The relevant custom is generally expressed in the form of an expert physician witness' opinion.[47] Because physician testimony is necessary to establish the applicable standard of care, medical expert testimony is virtually unavoidable under the present system of medical negligence.

Proper jury understanding requires expert testimony because medicine involves a body of knowledge beyond the understanding of the

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42. *See* Shilkret v. Annapolis Emergency Hosp. Ass'n, 349 A.2d 245, 248-52 (Md. 1975).

43. *Standard of Care*, *supra* note 41, at 614-20.

44. *Id.*

45. *See* Keeton, *supra* note 10, at 358.

46. Hall, *supra* note 26, at 126. *See also* Allan H. McCoid, *The Care Required of Medical Practitioners*, 12 VAND. L. REV. 549, 605-09 (1959). *But see, e.g.*, Helling v. Carey, 519 P.2d 981 (Wash. 1974). *Helling* is a well-known case finding a physician liable despite showing compliance with an established custom. In *Helling*, the court ruled that the defendant physician had followed the customary practice. However, the court held that compliance with the customary practice alone did not guarantee exculpation of the defendant physician. The *Helling* court concluded that the jury could find the defendant physician negligent notwithstanding his compliance with the established custom. *See also* Toth v. Community Hosp. at Glen Cove, 239 N.E.2d 368 (N.Y. 1968); Morgan v. Sheppard, 188 N.E.2d 808 (Ohio Ct. App. 1963).

47. *See, e.g.*, Gilman v. Choi, 406 S.E.2d 200 (W. Va. 1990) (recognizing that, in limited circumstances, application of the doctrine of res ipsa loqitur could avert the need for expert testimony).

average lay person.[48] Thus, only a physician, as an expert witness, may testify as to the applicable standard of care and give an opinion as to whether or not the defendant physician breached that standard.[49] The plaintiff must present medical expert testimony at trial to establish a prima facie case of negligence.[50] As a practical matter, the defendant physician is then forced to put on contrary expert testimony to rebut the opposing expert's conclusions.[51] The judge and jury play no role in evaluating the defendant physician's conduct directly. Rather their role is limited to evaluating the persuasiveness of the expert witness' testimony in light of all other evidence.[52]

Generally, expert physician witnesses base their testimony on how they would have conducted themselves or how they believe other physicians in the applicable comparison group would have conducted themselves in the particular situation at issue.[53] Such a basis for testimony, however, is incorrect.[54] Consequently, the correct process of comparing the defendant's conduct with established professional norms degenerates into a contest of credentials between the opposing experts. For instance, when the plaintiff's expert testifies that the defendant's acts or omissions were not within the standards of the profession, she is really saying only that *she* "would not have treated the patient that way."[55]

This exposition of the particular habits of testifying physicians is exacerbated when there are no standards, recommendations, or guidelines published by medical specialty societies, physician groups, or the like to guide the testifying physician.[56] As a result, defendant physicians are often held to a standard of care that reflects the "habit" of the medical expert testifying.[57] Some commentators have decried such

48. Hall, *supra* note 26, at 126.
49. *See* PROSSER & KEETON, *supra* note 29, § 32.
50. *Id.*
51. Kinney & Wilder, *supra* note 33, at 440.
52. Keeton, *supra* note 10, at 351-54.
53. Hall, *supra* note 26, at 127.
54. *Id.*
55. *Id.*
56. Kinney & Wilder, *supra* note 33, at 442.
57. *See* Keeton, *supra* note 10, at 361-62.

arbitrary standards.[58] Accordingly, they have encouraged courts to move toward standards based on what ought to be done rather than on "customary" practice.[59]

To combat the potential for a swearing match in medical negligence cases, there has developed an "error of judgment" rule.[60] Under this doctrine, if two or more acceptable schools of thought exist on a particular course of medical treatment, a physician is not negligent for choosing one course over another.[61] In theory, the error of judgment rule permits a physician to exercise alternative treatment methods by admitting evidence of an accepted course of treatment.[62]

In practice, however, the error of judgment rule does little to remedy the dilemma faced by juries who are forced to believe one expert's opinion over another. Juries are still faced with the daunting task of assessing the credibility of the representative experts. Thus, what began as a trial against an allegedly negligent physician becomes a trial centered around two expert witnesses. If the physician can establish a single appropriate standard of care in a particular instance and prove compliance with that standard, the defendant physician should have an affirmative defense to liability.[63] An appropriate standard of care defense should be rebuttable by the plaintiff only through evidence of non-compliance with the accepted standard, rather than testimony as to a *different* accepted standard.

C. *Medical Malpractice In West Virginia*

Before discussing the legal effects of practice guidelines generally, it is necessary to put the law of medical malpractice in West Virginia in perspective. After a brief comment on the background of West Vir-

58. Joseph H. King, Jr., *In Search of a Standard of Care for the Medical Profession: The "Accepted Practice" Formula*, 28 VAND. L. REV. 1213, 1235-36 (1975).

59. *Id.*

60. Hall, *supra* note 26, at 128.

61. *Id.*

62. *Id.* at 127-29.

63. For further discussion of this notion, *see infra* Part IV.B.

ginia medical malpractice law, this section reports on the current state of the law.

1. History

Like most states, the standard of care for physicians in West Virginia was historically based on the existing standard of care in the community — a "locality" standard.[64] In the late nineteenth century, the duty of a physician to a patient was "such reasonable, ordinary care, skill and diligence as physicians and surgeons in the same neighborhood, in the same general line of practice, ordinarily have and exercise in like cases."[65] The current locality rule was expressed in 1906 in *Dye v. Corbin*,[66] where the Supreme Court of Appeals of West Virginia held that:

> [A] physician is not required to exercise the highest degree of skill and diligence possible in the treatment of an injury or disease[,] . . . he is only required to exercise such reasonable and ordinary skill and diligence as are ordinarily possessed and exercised by the average of the members of the profession in good standing, in similar localities and in the same general line of practice, regard being had to the state of medical science at the time.[67]

The traditional locality rule in West Virginia, however, has not survived modern scrutiny. The Supreme Court of Appeals began to chip away at the locality rule as early as 1967.[68] Although the rule was not completely abandoned, the court noted that the historical bases for the rule were no longer applicable. Specifically, the court stated:

> The locality rule came into being in the 19th century and was premised upon the thought that is was unfair to hold the country doctor to the same stringent standard as the supposedly more learned doctors practicing in large urban centers . . . . [However, d]ue to highly improved modes of transportation, most physicians have at their disposal adequate to excellent hospital facilities. In addition, the now ready means of communication has

64. *Id.*
65. Lawson v. Conaway, 16 S.E. 564, 567 (W. Va. 1892).
66. 53 S.E. 147 (W. Va. 1906).
67. *Id.* at 149.
68. Hundley v. Martinez, 158 S.E.2d 159 (W. Va. 1967).

> permitted the doctor, regardless of his location, to keep abreast of recent medical developments and practices . . . . In view of these obvious transformations in today's society, the reasons for the strict application of the "locality" rule have largely disappeared.[69]

Some form of the locality rule and its basic principles remained in West Virginia up until 1986, when the rule was expressly abolished.[70] In *Paintiff v. City of Parkersburg*, the court found that:

> [O]ur own prior cases have so eroded the rule that it is but a shadow of its former self and that medical practice in West Virginia has changed to such an extent that there is no longer any social policy to be served by allowing a vestige of the rule to linger. Therefore, the locality rule in West Virginia medical malpractice cases is abolished.[71]

Although the judiciary expressly abolished the locality rule in West Virginia, common law in the state still recognizes the "error of judgment" rule.[72] In West Virginia, the error of judgment rule states that "[i]f a physician or surgeon, in a given case, adopts an established or approved method of treatment and is not negligent or careless in the application thereof, he is not liable, even for injuries caused by such treatment."[73]

2. The Medical Professional Liability Act of 1986

Soon after the abandonment of the locality rule in 1986 by judicial decree,[74] the West Virginia Legislature passed the Medical Professional Liability Act (the Act).[75] For a plaintiff to recover damages under

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69. *Id.* at 166-67.

70. *See* Paintiff v. City of Parkersburg, 345 S.E.2d 564 (W. Va. 1986).

71. *Id.* at 565.

72. *See, e.g.*, Browning v. Hoffman, 103 S.E. 484 (W. Va. 1920); Maxwell v. Howell, 174 S.E. 553 (W. Va. 1934).

73. *Browning*, 103 S.E. at 487.

74. In fact, the West Virginia Medical Professional Liability Act was signed into law only three months following the Supreme Court of Appeals' opinion in Paintiff v. City of Parkersburg, 345 S.E.2d 564 (W. Va. 1986). *See* Franklin D. Cleckley, *A Free Market Analysis of the Effects of Medical Malpractice Damage Cap Statutes: Can We Afford to Live with Inefficient Doctors?*, 94 W. VA. L. REV. 11 (1991).

75. W. VA. CODE §§ 55-7B-1 to -11 (1994). The Act made sweeping changes in the

the Act, the plaintiff must demonstrate that: "the health care provider failed to exercise that degree of care, skill and learning required or expected of a reasonable, prudent health care provider in the profession or class to which the health care provider belongs acting in the same or similar circumstances."[76] The Act also requires expert testimony to establish the applicable standard of care and whether or not the defendant physician breached the applicable standard of care.[77]

Because the current law ordinarily requires the plaintiff to present expert testimony to establish a prima facie case of medical negligence,[78] the defendant generally must counter such testimony with an expert of her own. What ensues is the often criticized "battle of experts."[79] Moreover, because the jury must ultimately decide whether or

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arena of medical malpractice litigation. In addition to the legislative abolishment of the locality rule, the act placed a cap of $1,000,000 on non-economic damages and prohibited a stated dollar amount in any medical malpractice complaint. As this Note addresses only the applicable standards of care for physicians, these other legislative achievements are beyond the scope of this discussion. For a very thorough criticism of the Act, however, *see* Cleckley, *supra* note 74.

76. W. VA. CODE § 55-7B-3 (1994). Specifically, this section states:

> The Following are necessary elements of proof that an injury or death resulted from the failure of a health care provider to follow the accepted standard of care: (a) The health care provider failed to exercise that degree of care, skill and learning required or expected of a reasonable, prudent health care provider in the profession or class to which the health care provider belongs acting in the same or similar circumstances; and (b) Such failure was a proximate cause of the injury or death.

Id.

77. W. VA. CODE § 55-7B-7 (1994). Specifically, this section states:

> The applicable standard of care and a defendant's failure to meet said standard, if at issue, shall be established in medical professional liability cases by the plaintiff by testimony of one or more knowledgeable, competent expert witnesses if required by the court. Such expert testimony may only be admitted in evidence if the foundation, therefor, is first laid establishing that: (a) the opinion is actually held by the expert witness; (b) the opinion can be testified to with reasonable medical probability; (c) such expert witness possesses professional knowledge and expertise coupled with knowledge of the applicable standard of care to which his or her expert opinion testimony is addressed; (d) such expert maintains a current license to practice medicine in one of the states of the United States; and (e) such expert is engaged or qualified in the same or substantially similar medical field as the defendant health care provider.

Id.

78. *See supra* Part II.B.2.

79. *See* Gary W. Kuc, Comment, *Practice Parameters as a Shield Against Physician*

not the defendant physician met the applicable standard of care, great potential remains for a smooth-talking expert to mislead the jury.[80] Thus, because the smoothest talkers will generally charge the most for their services,[81] disregarding the issue of negligence or non-negligence, the advantage lies in the party with the greater financial resources.

Indeed, the Act requires physician expert witness testimony because the relevant facts surrounding the case are generally far too technical and specialized for the unaided understanding of lay jurors.[82] Extension of this premise leads one to the virtually unavoidable conclusion that the jury bases its opinion *solely* on what it sees and hears from the experts. It is this battle of the experts and great potential for disparate treatment of physicians from case to case, that implementation of practice guidelines would seek to avoid.

III. THE HISTORY OF PRACTICE GUIDELINES

After a brief background discussion of practice guidelines, this Part focuses on the effect of the implementation of practice guidelines into the existing system of medical malpractice litigation and opines that such an implementation would benefit all parties unfortunate enough to be involved in medical malpractice litigation.

A. Background

Late in the 1980s, practice guidelines emerged as a response by the medical community to charges that the medical standard of care was "highly variable, with no obvious explanation."[83] Specifically, critics argue that "because physician conduct is currently measured by

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Liability, 10 J. CONTEMP. HEALTH L. & POL'Y 439, 443 (1993).

80. "[J]uries are often poorly positioned to choose reliably between the well-argued, but often highly confusing, theories of the two side's experts. As a result, they [the jurors] often fall back on such irrelevancies as the witnesses' demeanor and style of presentation." C. HAVIGHURST, HEALTH CARE LAW AND POLICY 778 (1988).

81. *See* Michael P. Ambrosio & Denis F. McLaughlin, *The Use of Expert Witnesses in Establishing Liability in Legal Malpractice Cases*, 61 TEMP. L. REV. 1351, 1394 (1988).

82. *See supra* note 46 and accompanying text.

83. David M. Eddy, *The Challenge*, 263 JAMA 287, 287 (1990).

the conduct of other members of the medical profession, whatever a physician decides is, by definition, correct."[84] Establishment of uniform guidelines promises to curb this "internal" standard setting by providing high quality, uniform, and predictable medical procedures that will serve to measure appropriate conduct in a given clinical situation.

Practice guidelines, in one form or another, and for one purpose or another, have existed for centuries.[85] Guidelines originated as theoretical pronouncements of proper medical procedures.[86] In the late 1980s, guidelines shifted away from theoretical, passive expressions of clinical decision making to active medical management tools.[87] Moreover, the practice guideline phenomenon promises to continue into the 1990s.[88]

B. Development

The most important issue that participants in medical malpractice litigation must resolve in order to effectively implement practice guidelines is the promulgation of guidelines. Two theories have emerged on the development of fair and acceptable practice guidelines — the professional model and the political model.[89] While these two theories endorse different authority for guideline development, both theories share a common goal: the development and application of uniform, predictable standards of care in particular clinical situations.

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84. *Id.*

85. David M. Eddy, *Practice Policies: Where Do They Come From?*, 263 JAMA 1265, 1265 (1990).

86. *See* John D. Ayres, *The Use and Abuse of Medical Practice Guidelines*, 15 J. LEGAL MED. 421, 421 (1994).

87. Kuc, *supra* note 79, at 446.

88. Anne-Marie Audet et al., *Medical Practice Guidelines: Current Activities and Future Directions*, 113 ANNALS INTERNAL MED. 709, 709 (1990).

89. *See* Clark C. Havighurst, *Practice Guidelines for Medical Care: The Policy Rationale*, 34 ST. LOUIS U. L.J. 777 (1990). Mr. Havighurst was found to be the foremost authority on the theories of guideline development. His article, one of many he has authored on the subject, was a great help and an extensive source of information for this Note.

1. The Professional Model

As its name suggests, the professional model endorses the creation of practice guidelines solely by the medical professionals most familiar with the area of specialty in question.[90] The ostensible rationale underlying this notion is that physicians, as everyday practitioners and scientists in particular specialties, are in the ideal position to develop accurate and applicable standards.[91] A fear expressed by some commentators, however, is that endorsement of such a theory encourages physicians to master their own malpractice destiny by setting their own standards of care.[92]

Under the professional model, the law will evaluate the practices of physicians only under professional norms and standards.[93] This model purports to best serve the patient by combining scientific knowledge with an overarching dedication to patient welfare.[94] The professional model also supports a high degree of physician autonomy. The physician is an expert, is closest to the situation, and is, in most cases, motivated by a concern for the individual patient's health.[95]

Foremost, the professional model endorses the notion that professional groups, especially the societies recognized in various specialties, should develop and validate practice guidelines.[96] Such development and validation, according to the professional model, ensures that the guidelines will represent a consensus within the profession.[97] Additionally, the professional model suggests that guidelines should not be absolute standards, but flexible parameters tolerant of diversity throughout the profession.[98]

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90. *Id.* at 785. *See also*, Clark C. Havighurst, *The Professional Paradigm of Medical Care: Obstacle to Decentralization*, 30 JURIMETRICS 415 (1990); Clark C. Havighurst, *Doctors and Hospitals: An Antitrust Perspective on Traditional Relationships*, 1984 DUKE L.J. 1071.

91. Havighurst, *supra* note 89, at 784.

92. *Id.* at 785.

93. *Id.* at 784-86.

94. *Id.*

95. *Id.*

96. Havighurst, *supra* note 89, at 785.

97. *Id.*

98. *Id.* (citing Winslow & Nazarios, *AMA, Rand Go After Modern Ill: Unneeded Pro-*

Subscribers to the professional model find support for this model in the fact that professionals are in a superior scientific position to develop guidelines.[99] Arguably, paramount to the efficacy of practice guidelines is the scientific accuracy of the guidelines. Guidelines must reflect sophisticated research concerning the outcomes and effectiveness of certain courses of medical treatment.[100] Therefore, the task of developing guidelines falls initially within the purview of medical scientists.[101] The practitioner then plays an important role in interpreting and translating the highly technical research results into complete and useful formulae of medical procedures.[102]

Physicians, as daily practitioners and researchers, are, indeed, an important component of the practice guideline development process. However, to allow physicians alone to establish acceptable practice guidelines may provide them with too much control over their own liability.[103] Additionally, a single-sided development committee would lack diverse interests which provide viewpoints not otherwise considered as well as a sense of impartiality in guideline creation. This Note proposes that the following political model of development is the appropriate method of developing practice guidelines.

2. The Political Model

The political model attempts to mitigate the potential of the professional model to develop only physician-oriented practice guidelines by including different members of the interested public in the development process.[104]

If practice guidelines are not developed by members of the professional community, perception of the required conclusive effect of the guidelines may be lost.[105] The developing committees of practice

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cedures, WALL ST. J., Mar. 22, 1990, at B1).

99. *Id.* at 786.

100. *Id.*

101. Havighurst, *supra* note 89, at 786.

102. *Id.*

103. *See* Hall, *supra* note 26, at 130.

104. *See id.* at 130-31.

105. *Id.*

guidelines need not be comprised solely of medical practitioners to receive authoritative professional status. If independent organizations, representative of diverse community interests, including physicians, base their standards on professional literature and practical experience, the resulting guidelines should still have conclusive effect as a statement of the standard of care.[106] Although the political model is sometimes challenged as the means to a political end,[107] it is arguably the most effective development system for practice guidelines.

The key element distinguishing the professional model from the political model is the incorporation of non-medical interests in guideline development.[108] Ideally, the inclusion of various non-medical interests will result in guidelines that reflect concerns that a wholly professional development team may ignore.[109] The incorporation of non-medical concerns into practice guideline development provides an important advantage — credibility.[110]

Opponents of the political model, particularly physicians, fear that this model will impose static and inflexible standards.[111] Participation by physicians and their colleagues in the creation of guidelines would greatly abate this fear of inflexibility.[112] Indeed, because practice guidelines ultimately dictate the quantity and quality of care given to particular patients, the majority of the members of development organizations are likely to be physicians. Thus, physicians would feel more secure in guideline development and enforcement in the arena of medical malpractice litigation.

3. Conclusion

Although the professional and political models differ in several respects, both models share a common goal — the establishment of a

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106. *Id.* at 130.

107. *See generally* Havighurst, *supra* note 89, at 786-88.

108. *Id.* at 787.

109. For example, the detrimental effects of medical malpractice on insurance companies, local and national economics, and legal issues.

110. *See generally* Havighurst, *supra* note 89, at 786-88.

111. *Id.* at 788.

112. *See id.* at 784-85.

single set of standards to govern health care. "Under both models, the *raison d'être* of practice guidelines is simply to provide an improved set of standards to which society — physicians, payors, courts, and others — can look for authoritative guidance on the appropriateness of treatment."[113]

The notion that medical professionals are the only persons capable of developing acceptable guidelines can be clearly supported by the above reasoning. However, the threat of a system of guidelines geared toward protecting the members of the medical profession, instead of being concerned with the quality of care and standardization of medical procedures, requires that a pure professional model not be adopted. The guidelines purport to enhance the medical profession in ways other than purely scientific — cost control, insurance issues, litigation, etc. Therefore, there must be a method of checking and balancing the promulgation of guidelines through scrutiny in the form of committees of specialists in the other areas of the guidelines' application — i.e., economists, politicians, and lawyers.[114]

IV. EFFECT OF GUIDELINES ON EXISTING LAW

If developed by competent, rational, and impartial committees, practice guidelines will likely win legislative approval as appropriate standards of care.[115] However, because the guidelines are evidence in the form of written pronouncements of medical standards, the rules of evidence govern their admissibility at a trial. Therefore, before analyzing the potential effect of practice guidelines in medical malpractice litigation, an understanding of the relevant rules of evidence that will determine the admissibility of the guidelines is necessary. After discussing the rules of evidence, this Note will endorse the use of practice guidelines to dictate the applicable standard of care in medical malpractice litigation. Finally, this Part will examine briefly the existing

113. *Id.* at 790.

114. *Id.* at 784.

115. *See generally* Hall, *supra* note 26, at 26-34. *See also* Havighurst, *supra* note 89, at 786-92.

Maine Medical Liability Demonstration Project[116] as an example of the practical effects of practice guidelines.

A. Evidentiary Obstacles

To be admitted into evidence at a trial, the proponent of the evidence must prove the evidence to be relevant, reliable, and authentic.[117] Therefore, each of these criterion is discussed below.

1. Relevancy

Evidence is relevant if it has "any tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without the evidence."[118] In order to show that a particular guideline is relevant, the party seeking to introduce it must demonstrate that it addresses the particular medical procedure at issue.[119] The proponent of the particular practice guidelines at issue will most likely establish the relevance of a particular guideline through medical expert testimony.[120] Similar to the present method of proving the standard of care in medical malpractice cases, expert testimony will be required to make any highly technical issues clear to the jury.[121]

An important difference in the role of the expert in a case employing practice guidelines as opposed to the current system of medical liability is that the expert will not testify, based on her own opinion, about the standard of care. Rather, expert testimony is only required to show that a particular pre-established standard is relevant to the case in issue. One or more medical experts will likely clarify any clinical or

116. ME. REV. STAT. ANN. tit. 24, §§ 2971-79 (West Supp. 1994).

117. *See* FED. R. EVID. 401, 801 & 901.

118. FED. R. EVID. 401.

119. *See, e.g.*, Brennan, *supra* note 16, at 75.

120. Most states require highly technical evidence, such as a practice guideline, to be accompanied by expert testimony. This requirement ensures that the judge and jury will understand the technical evidence and enables an informed decision regarding its relevance. *See supra* notes 48-52 and accompanying text.

121. *See supra* notes 48-52 and accompanying text.

specialized facts necessary for clear understanding by the jury. The technical aspects of medical malpractice litigation also require an expert or experts to explain whether a particular practice guideline has been followed in the case. Thus, the expert's role in a trial involving practice guidelines is only to aid the jury in determining the *factual* setting of the case.

2. Reliability

Once the offering party establishes that the particular practice guideline is relevant to the circumstances at issue, that party must also show that the practice guideline is admissible despite the evidence rule against hearsay.[122] The rule against hearsay is intended to exclude certain unreliable evidence from the trial.[123] Both the West Virginia and Federal Rules of Evidence define hearsay as "a statement, other than one made by the declarant while testifying at the trial or hearing, offered in evidence to prove the truth of the matter asserted."[124] To be reliable, statements that are made out of court and are offered in court to prove the truth of the matter asserted must find an exception to the hearsay rule.[125] Writings, such as medical practice guidelines, are statements and must, therefore, pass a hearsay objection before they will be admitted into evidence.[126]

The underlying purpose of the hearsay rule is to exclude certain statements not made under oath or otherwise subject to punishment for their falsity,[127] unless other factors indicate reliability.[128] Legislatures and courts have recognized many exceptions to the hearsay rule includ-

122. The guidelines at issue will almost universally qualify as out of court statements offered for the truth of the matter asserted that must clear the hearsay hurdle to admissibility.

123. *See* GRAHAM C. LILLY, AN INTRODUCTION TO THE LAW OF EVIDENCE 180-82 (2d ed. 1987).

124. W. VA. R. EVID. 801(c); FED. R. EVID. 801(c).

125. FED. R. EVID. 801.

126. FED. R. EVID. 801(a)(1).

127. JOHN W. STRONG ET AL., MCCORMICK ON EVIDENCE § 245, at 426 (4th ed. 1992).

128. *See* FED. R. EVID. 803(24), 804(5).

ing the "learned treatises" exception[129] and the "public records" exception.[130] Unless practice guidelines receive the status of public records,[131] the hearsay rule will be the critical barrier to their admissibility.

Learned treatises are "statements contained in published treatises, periodicals, or pamphlets on a subject . . . established as a reliable authority by the testimony or admission of the witness or by other expert testimony or by judicial notice."[132] Because these statements are subject to review by knowledgeable peers and the statements are generally accepted by the particular community, courts generally consider learned treatises more reliable than other types of statements.[133] Therefore, learned treatises are generally admissible in court despite the hearsay rule. Theoretically, practice guidelines could be admissible under this exception to the hearsay rule. There are, however, limitations to the learned treatise exception, discussed below, which largely eliminate the exception's usefulness in medical malpractice litigation.

First, because expert testimony is generally required to establish the reliability of a particular treatise,[134] the learned treatise exception raises problems of witness credibility and battling experts.[135] For instance, if one party opposes the introduction of a particular practice guideline, that party must hire an expert to testify against admissibility. Indeed, the primary reason for implementation of a system of practice guidelines is the substantial elimination of expert testimony.[136] At the very least, a practice guideline system will limit expert testimony to factual and technical clarifications to the jury rather than testimony about the standard of care in a given procedure.[137]

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129. FED. R. EVID. 803(18).

130. FED. R. EVID. 803(8).

131. Public records are defined as "[r]ecords, reports, statements, or data compilations, in any form, of public offices or agencies . . . ." FED. R. EVID. 803(8). Unless the guidelines are promulgated by (or under the authority of) local, state or federal agencies, their status as public records is unlikely.

132. FED. R. EVID. 803(18).

133. STRONG ET AL., *supra* note 127, § 321, at 533-35.

134. *Id.*

135. *See supra* notes 79-80 and accompanying text.

136. *See supra* Part II.C.2.

137. *See supra* note 46 and accompanying text.

Second, under the learned treatise exception, the proponent of the treatise may only *read* the treatise into evidence and may not offer it as an exhibit.[138] This limitation requires an expert to take the witness stand to read the practice guidelines to the jury. Finally, only on cross-examination may a party call a learned treatise to the witness' attention.[139] Thus, if a party relies on the learned treatise exception to admit practice guidelines, that party must do so through an adverse witness. In such a case, the proponent of the practice guideline cannot use the practice guideline as part of its case in chief. This Note proposes that the courts permit *either* party to use practice guidelines. Indeed, if a party may only utilize practice guidelines through questioning of an adverse witness, that party will not likely rely on practice guidelines to formulate the applicable standard of care.

A more suitable exception to the hearsay rule for practice guidelines is the "public records" exception.[140] The public records exception is available only if the applicable practice guidelines are "records, reports, statements, or data compilations in any form of a public office or agency" made pursuant to a duty imposed by law.[141] A legislative proposal implicating the use of practice guidelines may designate special advisory committees or a public agency such as the West Virginia Board of Medicine to formulate and approve practice guidelines.[142] Therefore, practice guidelines are likely to be amenable to the public records exception. Because the public records exception eliminates the need for expert introduction of practice guidelines[143] and allows them to be utilized as exhibits,[144] this exception more effectively furthers

138. FED. R. EVID. 803(18).

139. *Id.*

140. FED. R. EVID. 803(8).

141. *Id.*

142. This Note proposes a legislative reform in medical malpractice litigation that closely resembles Maine's "Medical Liability Demonstration Project" (the Maine Project). ME. REV. STAT. ANN. tit. 24, §§ 2971-79 (West Supp. 1994). Under the Maine Project, the Board of Registration in Medicine is directed to review the practice policies that are developed by the Advisory Committees, to approve the practice policies that are appropriate for each medical specialty area, and to adopt them as rules under the Maine Administrative Procedure Act. ME. REV. STAT. ANN. tit. 24, § 2973 (West Supp. 1994).

143. There is no requirement that public records be accompanied by expert testimony in order to be admissible. *See* FED. R. EVID. 803(8).

144. Similarly, there is no limitation on the use of public records once they are admit-

the desired objective of simplification of the medical malpractice litigation process.

3. Authenticity

The final evidentiary hurdle facing practice guidelines is authenticity. Authenticity requires that the party offering evidence must demonstrate that evidence to be what its proponent claims it to be.[145] Certain documents are "self-authenticating" and require no independent authentication.[146] Public records under seal[147] or certified copies of such records[148] are self-authenticating and, therefore, require no "extrinsic evidence of authenticity."[149] Because practice guidelines are likely to be public records under the proposed system of development discussed previously,[150] such guidelines will have little difficulty clearing the authenticity hurdle.

B. What Effect Practice Guidelines Should Have

"There is simply too much human variation to develop a predetermined standard of care for every possible clinical problem a physician might confront."[151] However, the introduction of practice guidelines would correct many of the shortcomings of the current system of medical malpractice law. Development of practice guidelines that are sufficiently concrete to operate as clinical protocol is mandatory for this objective. Otherwise, practice guidelines will have no more effect than mere evidence of the standard of care.[152]

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ted into evidence. *See* FED. R. EVID. 803(8).

145. FED. R. EVID. 901(a).

146. FED. R. EVID. 902.

147. FED. R. EVID. 902(1).

148. FED. R. EVID. 902(4).

149. FED. R. EVID. 902.

150. *See supra* Part III.B.

151. Hirshfeld, *supra* note 7, at 1559.

152. Medical texts and journals, provided they escape the limitations of the hearsay exclusion and are relevant, are used today simply as "evidence of the standard of care," but are not absolute determinants of the applicable standard. Most states permit the introduction into evidence of "learned treatises" as exceptions to the hearsay rule. *See* J. MCCORMICK,

Practice guidelines should have the force and effect of law insofar as they establish appropriate standards of care in particular cases of alleged medical negligence. Currently, practice guidelines may be introduced into evidence in most states provided that they meet the aforementioned evidentiary criteria.[153] Once admitted, however, a jury is not obligated to apply the practice guideline as the standard of care. Thus, under the current majority of state law, practice guidelines have the same effect as any other learned treatise: a tool for expert witnesses.

Under the system proposed by this Note, the introduction of practice guidelines should be permitted by either party. However, practice guidelines should have conclusive effect only as an affirmative defense. In other words, liability cannot result if the physician introduces an acceptable practice guideline with which she complied. According to the well-settled "error of judgment" rule, even if the practice guideline in question represents only one alternative method, so long as that method is acceptable, the physician has met her duty of care.[154]

Plaintiffs should also be permitted to introduce applicable practice guidelines in medical malpractice litigation. However, the same conclusive effect of the guidelines cannot be afforded to plaintiffs. By virtue of the well established principle that several valid and acceptable schools of thought may exist,[155] introduction of a single practice guideline by the plaintiff coupled with proof of non-compliance cannot be conclusive of a breach of the standard of care.[156] Unless a plaintiff has the ability to introduce every practice guideline without exception to show that the physician failed to comply with *any* established standard, the practice guidelines should have, for the plaintiff, only limited evidentiary effect. Indeed, if a defendant physician could only rely on

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MCCORMICK ON EVIDENCE § 321 (Cleary, 3d ed. 1984).

In most of these states, however, the rules of evidence require that a qualified expert witness be called to read the medical text into evidence, and the text itself cannot be introduced as an exhibit. *See, e.g.*, FED. R. EVID. 803(18).

153. *See* Edward B. Hirshfeld, *Should Practice Parameters Be The Standard of Care in Malpractice Litigation?*, 266 JAMA 2886 (1991).

154. Hall, *supra* note 26, at 130.

155. *See supra* notes 60-62 and accompanying text.

156. Hall, *supra* note 26, at 130.

one practice guideline, then there is no reason to limit its conclusive effect to defendants only, for failure to comply would result in negligence *per se*.

C. *Maine Demonstration Project*

Maine, in its Medical Liability Demonstration Project (the Project),[157] is currently experimenting with the idea of giving conclusive effect to practice guidelines. Under the Project:

> In any claim for professional negligence against a physician . . . participating in the project . . . in which a violation of the standard of care is alleged, only the physician . . . may introduce into evidence, as an affirmative defense, the existence of the practice parameters . . . developed and adopted pursuant to [the project] for that medical specialty area.[158]

Both the burden of establishing the appropriate guideline as well as demonstrating compliance with that guideline rest with the defendant physician. Once established, the plaintiff may introduce rebuttal evidence to show non-compliance.[159] Thus, once compliance with the guideline is established by the defendant physician, the jury cannot find the physician liable for medical negligence. Because only the defendant physician may introduce the practice guidelines into evidence, the Project has met with some disfavor by the plaintiffs' bar in Maine.[160] Predictably, the medical community has largely endorsed the Project, as it provides a great deal of protection for the medical participants.[161] The Project is currently without objective evaluation however, because to date, no cases of alleged medical negligence have gone to trial under the Project.[162]

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157. ME. REV. STAT. ANN. tit. 24, §§ 2971-79 (West Supp. 1994).
158. ME. REV. STAT. ANN. tit. 24, § 2975 (West Supp. 1994).
159. *Id.*
160. *See Maine Doctors Test Lawsuit Preventive*, N.Y. TIMES, Aug. 19, 1994, at A23.
161. *Id.*
162. *Id.*

V. LEGISLATIVE PROPOSAL FOR WEST VIRGINIA

A legislative resolution would provide a possible remedy to current problems of medical malpractice litigation by affirmatively declaring what effect practice guidelines should have in medical malpractice litigation.[163] After a brief introduction, this Part will address the logic behind a statutory initiative and then propose a statute for West Virginia.

Legislative proposals which have attempted to confer the force and effect of law upon practice guidelines have fallen short of making them predetermined standards of care in medical malpractice litigation.[164] Because these attempts at statutory reform provide an unequal benefit to the defendant physician,[165] unanimous support is impossible. Practice guideline proposals, such as the Maine Demonstration Project, most frequently recommend practice guidelines for use by physicians in defending malpractice claims.[166] The plaintiff may only refer to the practice guidelines as evidence of non-compliance after the defendant physician has introduced them.[167] Some commentators believe that this result is political: "policymakers are concerned that physicians would resist the development and implementation of practice [guidelines] if they became standards of care that a physician was obligated to follow to avoid liability."[168]

A. Logic Behind Statutory Reform

The legislative proposal made by this Note is based in large part on the Maine Project.[169] However, recognizing some of the pitfalls and criticisms of the Project,[170] and practice guidelines in general,

163. Hall, *supra* note 26, at 134.
164. Hirshfeld, *supra* note 153, at 2886.
165. *Id.*
166. *Id.*
167. ME. REV. STAT. ANN. tit. 24, § 2975 (West Supp. 1994).
168. Hirshfeld, *supra* note 153, at 2886.
169. *See supra* Part IV.C.
170. For example, the Maine statute permits only the defendant to introduce relevant guidelines. Additionally, the dearth of guidance in the Maine statute as to practice guideline

this Note has made subtle variations to the Maine Project in hopes of resolving those shortcomings.

The costly effects of defensive medicine claimed to result from rampant medical malpractice litigation[171] would quickly evaporate with blanket tort immunity for physicians who comply with accepted practice guidelines.[172] Physicians could then practice "cookbook medicine"[173] without fear of legal redress in the event of an unexpected and unfortunate result. However, to have such an absolute effect in a medical malpractice case, the guideline must be sufficiently narrow in design and in the medical procedure at issue.[174] Indeed, there exist infinite possible outcomes, medical and otherwise, in any given clinical setting. Thus, the design of a guideline narrow enough to dictate such an absolute legal effect, would be difficult, if not impossible.[175] Therefore, even if a guideline establishes the applicable standard of care, the arduous task of determining compliance by the physician remains before the jury.[176]

A possible solution is what has been termed a "variable immunity statute."[177] Under a variable immunity statute, in contrast to the Maine Project, the now factual question of the standard of care, becomes a question of law for the judge.[178] The effect is to charge the jury with the factual issue — determining compliance with the standard of care by the defendant physician.

Under a variable immunity statute, the judge determines whether or not a properly authoritative body promulgated the proffered practice guideline.[179] The judge, who is not bound by rules of evidence, will hear testimony from experts and other witnesses. The judge then makes

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development gives courts little assistance when determining guideline validity. For a discussion of the Maine Project, *see supra* Part IV.C.

171. *See supra* note 4 and accompanying text.
172. Hall, *supra* note 26, at 134.
173. *See* Edward Felsenthal, *Cookbook Care*, WALL ST. J., May 3, 1993, at A1.
174. Hall, *supra* note 26, at 134.
175. *Id.*
176. *Id.*
177. *Id.*
178. *Id.*
179. Hall, *supra* note 26, at 134-35.

a determination of the appropriate standard of care based on that evidence.[180] The judge will also be required to make the factual determination as to whether the particular practice guideline applies to the case in issue.[181]

The legislature should include some authoritative bodies whose practice guidelines were qualified *per se*, and leave to the judge the determination of other organizations' authority.[182] Again, in line with the previous discussion of practice guideline development, it is important that the developing authority should be comprised of not only physicians, but other interested persons such as lawmakers, insurers, and lawyers.[183] Thus, the judge would be somewhat limited by the discretion of a qualified developing body, but would also be free to make the determination based on a case by case analysis.[184] Most importantly, however, the judge will be governed by precedent. As more developing organizations are reviewed, a "list" of acceptable organizations will begin to materialize. Thus, both defendants and plaintiffs will be provided some guidance and predictability as to which organizations will qualify.

B. Proposed Statute

The discussions to this point, for the most part, have criticized the present system of physician liability. The following presents a statutory initiative to adopt a system of practice guidelines in medical malpractice litigation. The proposed statute is for use by the West Virginia Legislature as a simple model for reform.[185] The applicable portion of the statute would read:

Development of Practice Guidelines:

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180. *Id.* at 135.

181. *Id.*

182. *Id.*

183. For a discussion of proper entities to promulgate practice guidelines, *see supra* Part III.B.

184. *See* Hall, *supra* note 26, at 135.

185. Because the scope of this Note is limited to narrow issues of liability and the standards of care in medical malpractice litigation, provisions for insurance, court rules, and other such considerations are knowingly omitted.

Any organization purporting to issue practice guidelines determinative of applicable standards of care within particular medical specialties and in particular clinical situations must include, but not be limited to:

(1) One physician who is licensed in any state of the United States;

(2) One physician involved in the active practice of medicine in the particular medical specialty in question and is licensed to practice medicine in that particular specialty by a state of the United States;

(3) One physician who is licensed to practice medicine in the particular field of medicine in question in the State of West Virginia;

(4) One person, not a physician, representing the interests of payors of medical costs; and

(5) One person, not a physician, who represents the interests of consumers.

Content of Practice Guidelines:

The practice guidelines must define appropriate clinical indications and methods of treatment within that specialty of medicine. The practice guidelines must be consistent with appropriate standards of care and levels of quality. The practice guidelines must state, with reasonable certainty, the standard of care to which a reasonable physician practicing in the medical specialty in question, performing in the same or similar circumstances, should be held.

Application of Practice Guidelines in Professional Negligence Claims:

(1) Introduction by the defendant. In any claim for professional negligence against a physician who has, prior to the performing of the particular services in question, elected to comply with the standard of care as it is reflected in an accepted practice guideline, developed by a qualified organization, the physician may introduce into evidence, as an affirmative defense, the existence of the accepted practice guideline with which the physician allegedly complied.

(2) Introduction by the Plaintiff. In any claim for professional negligence against a physician who has, prior to performing the particular services in question, elected to comply with the standard of care

as it is reflected in an accepted practice guideline, developed by a qualified organization, the plaintiff may introduce into evidence, as evidence of the standard of care, the existence of the accepted practice guideline with which the physician allegedly did not comply.

(3) Burden of Proof. Any physician who pleads compliance with an accepted practice guideline as an affirmative defense to a claim of medical professional negligence has the burden of proving that the physician's conduct was consistent with the practice guidelines in order to rely upon the affirmative defense as the basis for a determination that the physician's conduct did not constitute medical professional negligence. If the plaintiff introduces into evidence an accepted practice guideline, the plaintiff will have the burden of proving that the physician's conduct did not comply with the particular accepted guideline in question in order to raise a rebuttable presumption that the physician did not meet the applicable standard of care and is, therefore, liable for medical professional negligence.

(4) No change in Burden of Proof. Nothing in this chapter alters the burdens of proof in medical professional negligence proceedings existing as of adoption of this legislation.

VI. CONCLUSION

Whether or not physicians and other critics correctly perceive the efficacy of the current model for physician liability, the effects of this perception cannot be doubted. Medical practitioners are practicing defensive medicine, paying exorbitant malpractice liability insurance premiums, and blaming it on the perceived shortcomings of the current system of medical malpractice litigation. By legislatively implementing practice guidelines as clear standards of care in medical negligence litigation, health care providers could rest assured that conformance with an established practice would protect them from liability. The existence of clear pronouncements of standards of care is currently presumed in medical malpractice litigation. This presumption is reflected by the fact that custom, presented by expert witnesses, plays such a vital role in malpractice litigation. However, this vital aspect of malpractice litigation assumes that which does not exist — established standards of care for physicians.

Functional equivalents of practice guidelines exist in medical journals and treatises and they are applied everyday in the practice of medicine. Use of these guidelines as effective defenses in medical malpractice cases would encourage their use by physicians. The results would be predictable standards and procedures which would provide physicians with clear and uniform standards of care. Physicians would practice less defensive medicine because defensive medicine would be legally obsolete.

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